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POLICIES AND GENERAL INFORMATION AGREEMENT
FOR PSYCHOTHERAPY SERVICES

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of specific concerns. Working to gain these benefits, however, requires effort on your part. Psychotherapy requires your active involvement, honesty and openness in order to change your thoughts feeling and/or behavior. During therapy remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. Additionally, you may experience anxiety, depression, insomnia, etc. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. There is no guarantee that psychotherapy will yield positive or intended results. During our work together I may draw on various psychotherapy approaches and techniques to helpfully find the best result for you individually.

Confidentiality: All information disclosed within sessions and in the written records pertaining to those sessions is confidential and may not be revealed to anyone without your (the client's) written permission, except where disclosure is required by law. Privacy and confidentiality are essential to the trust necessary for the process of therapy.

The law also entitles you to this right of "privilege of confidentiality". However, the law under special circumstances also obligates caretakers (i.e. therapists) to report to authorities any significant suspicion of imminent danger: to the client by self-harm, to someone the client is targeting for harm, or to dependent children or elder adults who are being subjected to abuse or neglect.

Furthermore, the legal system can attempt to subpoena medical record relevant to a legal matter without client consent. In couple and family therapy, confidentiality and privilege do not apply between the couple or among family members (i.e. "no secrets policy"). I will not release records to any outside party unless I am authorized to do so by "all" adult family members who were part of the treatment.

Telephone and Emergency Procedures: If you need to contact me between sessions, please call me at (818) 224-2248. If I am unavailable, feel free to leave a message on my

confidential voicemail. Please leave the best number to reach you at even if you think I have it. I will return your call as soon as possible. If a true emergency arises, you can contact me at (818) 625-7064. I check my voicemail several times a day unless I am out of town or on vacation. If I am going out of town or on a vacation and will not be reachable during a period of time, I will notify you in advance and will provide the name and number of a therapist who will be "on call" for me during the time I am unavailable. In an emergency, if you need to talk to someone right away, consider dialing **911 or proceeding to the nearest emergency room.** If during our work together I become concerned about your personal safety, the possibility of you injuring someone else or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law of prevent you from injuring yourself or others and to ensure that you receive the proper medical care you need. For this purpose, I may need to contact the person whose name you have provided on the initial intake sheet for emergencies.

Services and Fees: Clients are expected to pay at the end of each session. If you have insurance that may cover your treatment, you may request that I provide you with a receipt and a "super bill" which you can submit to your insurance company for reimbursement. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. My standard fee schedule is subject to change upon written notice and is expected to reflect community norms.

Cancellation/No Shows: Since scheduling of appointments involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment. This will allow time to offer your spot to someone else who may be on the waiting list. You will be financially responsible for the full fee if the session is missed without such notification. The only exception would be a true emergency which is out of your control.

Appointments that begin late: If we begin late because you arrived late, the session will end at the time it normally would have ended. If I am running behind schedule (which would be rare), the session will be of its normal duration of approx. 50 minutes.

Termination: You have the option of terminating our treatment relationship at any point. However, it would be preferable if you did not suddenly stop your therapy without discussing it with me first. My first concern is for your mental health and I will be happy to provide you with alternative provider referrals of people that may suit your needs.

Record Keeping: Both law and standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will provide the records to an appropriate and legitimate mental health professional of your choice.

SIGNATURE:

I have read the above Policies and General Information Agreement and by my signature am stating that I understand and agree to comply with them. I will receive a copy of this agreement upon request.

_____
Client Name (print)

_____ _____
Client Signature (or guardian) Date

_____ _____
Therapist Signature Date